

## Catawba 1 3Q/2012 Plant Inspection Findings

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### Initiating Events

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### Mitigating Systems

**Significance:** G Sep 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Inadequate 3 hour fire barrier between essential switchgear rooms**

An NRC-identified Green non-cited violation (NCV) of the Unit 1 and 2 Facility Operating Licenses, Condition 2.C.5, Fire Protection Program, was identified for failure to implement and maintain all provisions of the approved fire protection program. The inspectors identified gaps in the emergency switchgear room (ESR) hatch covers separating two fire areas containing redundant safe shutdown equipment which were not evaluated. The licensee placed the issue into the corrective action program and implemented fire watches and prohibited storage of transient combustibles in the area.

The inspectors determined the gaps in the ESR hatch covers was a performance deficiency (PD). The inspectors determined that the PD was more than minor because it was associated with the Mitigating System Cornerstone attribute of Protection against External Factors (fire) and adversely affected the cornerstone objective in that there was no reasonable assurance the gaps in the hatch covers would prevent fire propagation across the 3-hour fire rated barrier. The inspectors determined the finding was of very low safety significance (Green). The cause of this finding was related to the cross cutting-aspect to thoroughly evaluate problems such that the resolutions address causes and extent of condition as described in the corrective action program component of the Problem Identification and Resolution cross-cutting area. [P.1(c)] (Section 1R05)

Inspection Report# : [2012004](#) (*pdf*)

**Significance:** G Sep 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to maintain requalification examination integrity**

An NRC-identified non-cited violation (NCV) of 10 CFR 55.49, Integrity of examinations and tests, was identified for the licensee's failure to adhere to examination procedure standards that allow no more than 50 percent scenario overlap between examinations. The licensee subsequently revised the 2012 annual operating examination to preclude the scenario overlap issue that would have occurred and entered the issue in their corrective action program as PIP C-12-06949 and PIP C-12-06950.

This performance deficiency was more than minor because it was associated with the Human Performance attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective in that the failure to adhere to examination overlap standards adversely affected the quality of the administration of the operating exams. Using the Licensed Operator Requalification Significance Determination Process, this

finding was determined to be of very low safety significance (Green) because no actual compromise of the examinations occurred. The cause of the finding was related to the cross-cutting aspect of procedures of the resources component of the cross-cutting area of Human Performance. [H.2(c)] (Section 1R11)

Inspection Report# : [2012004](#) (*pdf*)

**Significance:** **W** Jun 18, 2012

Identified By: NRC

Item Type: VIO Violation

**Failure to Provide Vendor with Accurate Design Information**

Self-revealing findings were identified for the licensee's failure to follow EDM-141, Procurement Specifications for Services. The licensee did not identify the need for the blocking feature for the instantaneous underfrequency protective function in both the vendor specification and the supporting information provided to the vendor. The offsite power supply to Unit 1 would have been lost anytime there was a generator trip from high power without this blocking feature. This finding resulted in an apparent violation (AV) of Technical Specification (TS) 3.8.1, AC Sources – Operating, for Unit 1 because the installed modification resulted in inoperability of the offsite power source for both units. The finding does not represent an immediate safety concern because the licensee corrected the blocking function prior to unit restart. The violation was placed in the licensee's corrective action program as PIP C-12-3403.

The performance deficiency (PD) was more than minor because it affected the availability and reliability of the Equipment Performance attribute and adversely affected the Mitigating Systems cornerstone objective in that an offsite power supply would not have been available to mitigate expected operational transients and design basis events. For Unit 1, the significance was determined to be White. The PD was directly related to the aspect of accurate design documentation in the component of Resources in the cross-cutting area of Human Performance in that the engineering design procedures were not complete because there was no requirement for verification of non safety-related design changes. [H.2(c)]

Inspection Report# : [2012009](#) (*pdf*)

Inspection Report# : [2012010](#) (*pdf*)

**Significance:** **G** Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

**Safety-Related Manhole Sump Pump Discharge Outlet Blockage**

Green. A NRC-identified non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion III, Design Control, was identified for the licensee's failure to implement the requirements of their modification program. Surface grading work for the nuclear service water (RN) piping replacement modification was not reviewed to ensure it did not impact the CMH-2 sump pump function to eliminate accumulated water. Licensee's corrective actions included unclogging the sump pump discharge outlet, replacing the sump pump, and extending the height of the discharge outlet.

The performance deficiency was more than minor because it was associated with the Mitigating Systems cornerstone attribute of Protection Against External Factors - Flood Hazard and adversely affected the cornerstone objective in that the design modification activities affected the CMH-2 sump pump function to prevent water accumulation in the safety-related manhole structure. The inspectors determined that the finding was of very low safety significance because the accumulated water in CMH-2 did not result in the loss of operability or functionality of safety-related structures, systems, and components (SSCs). The finding was associated with the aspect of appropriate and timely corrective actions of

the Corrective Action Program component in the Problem Identification and Resolution cross-cutting area in that the licensee identified in August 2011 (PIP C-11-6342) that the sump pump discharge outlet needed to be raised; however, corrective actions were not implemented that would have prevented the blockage during the grading activities. [P.1(d)] (Section 1R06)

Inspection Report# : [2012002](#) (*pdf*)

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## **Barrier Integrity**

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## **Emergency Preparedness**

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## **Occupational Radiation Safety**

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## **Public Radiation Safety**

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## **Security**

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

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## **Miscellaneous**

Last modified : November 30, 2012